

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-045238**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3310

**FILED DEC 13 1962**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Richmond Heights</u>		c. CITY OR TOWN <u>University City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7500 Milan Ave</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Webster</u> Last <u>Felt</u>			4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/1902</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. B. Ittner</u>		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Henry Felt</u>			
13b. MOTHER'S MAIDEN NAME <u>Katie Mae Stallard</u>		14. NAME OF HUSBAND OR WIFE <u>Leta Lovelle Felt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			17. INFORMANT Address <u>Mr Ronald Felt 10204 Carlyle Ave</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Arteriolar Nephrosclerosis</u> DUE TO (c) <u>Agranulocytosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 week</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	

20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 10/13/62 to 11/12/62 and last saw her alive on 11/12/62.  
Death occurred at St. Mary's Hospital on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John M. McCarty M.D.</u>	22b. ADDRESS <u>4161 Linden Blvd St. Louis, Mo.</u>	22c. DATE SIGNED <u>11/13/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/15/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>		23e. REGISTRAR'S SIGNATURE <u>John M. McCarty M.D.</u>

24. FUNERAL DIRECTOR <u>Alexander &amp; Sons 6175 Delmar Blvd</u>	25. DATE RECD. BY LOCAL REG. <u>11-13-62</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF
18a	Arteriolar-Nephrosclerosis	Septicemia
18b	be left blank	Agranulocytosis
18c	be left blank	Iremia

BY AFFIDAVIT OF attending physician

MEDICAL CERTIFICATION

Dr. McCarthy

4161 Lindell Blvd

01.2-2638

2 to 5 P.M.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*JOSE MC CALLISTER*

Licensed Embalmer No. 2460

P. O. Address

*6135 Alma*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.